Appendix 14
Inpatient Dual-Entitlee Billing Instructions for Partial or No Part A Benefits

Use the following billing instructions for dual-entitlees with partial or no Medicare Part A benefits.

Part A Benefits Exhausted Prior to Admission (No Part A)

1. Bill Medicare for all Medicare Part B billable ancillaries for the noncovered Medicare Part A days. Wisconsin Medicaid allows and pays the coinsurance and any deductible on those Medicare-approved services through the crossover claim (automatic or paper submission — CT 31 — Outpatient Crossover).
2. Bill Wisconsin Medicaid for all inpatient charges including the Medicare Part B charges. In Items 39 to 41 of the UB-92 claim form use the value code 81 and state the total charges billed to Medicare Part B (not the Medicare payment amount). In Item 84 of the UB-92 claim form indicate Medicare disclaimer code "M-1." Wisconsin Medicaid pays the claim (CT 40 — straight Wisconsin Medicaid Inpatient) deducting the amount shown with value code 81 from the diagnosis related group (DRG) reimbursement since this amount was already paid through the crossover claim (CT — 31 Outpatient Crossover). Do not attach the Medicare Remittance Advice (RA) to this claim.
3. (Optional) Bill Medicare for the Professional Component charges on the CMS 1500 claim form. Wisconsin Medicaid allows and pays the coinsurance and any deductible on those Medicare-approved services through the crossover claim (automatic or paper submission — CT 30 — Professional Crossover).

Part A Benefits Exhausted Mid-Stay (Partial Part A)

1. Bill Medicare for all charges for the entire stay. Medicare approves and pays the Medicare Part A covered days. Wisconsin Medicaid allows and pays the coinsurance and any deductible on those Medicare-approved days through the crossover claim (automatic or paper submission — CT 50 — Inpatient Crossover).
2. Bill Medicare for all Medicare Part B billable ancillaries for the noncovered Medicare Part A days. Wisconsin Medicaid allows and pays the coinsurance and any deductible on those Medicare-approved services through the crossover claim (automatic or paper submission — CT 31 — Outpatient Crossover).
3. Bill Wisconsin Medicaid for all inpatient charges for the entire stay, including the Medicare Part B charges. In Items 39 to 41 of the UB-92 claim form, use both value codes 81 and 83.

   With value code 81, state the total charges billed to Medicare Part B (not Medicare Payment Amount).

   With Value code 83 state the Medicare Part A allowed amount. The Medicare Part A allowed amount is calculated from the Medicare RA by adding the Medicare paid amount, plus both the coinsurance amount and deductible amount. The total of these amounts must be listed in value code 83.

   In Item 84 of the UB-92 claim form, indicate Medicare disclaimer code "M-1."

   Wisconsin Medicaid pays the claim (CT 40 — straight Medicaid Inpatient) deducting the total amounts shown with value codes 81 and 83 from the DRG reimbursement since these amounts were already paid through the crossover claims (CT 31 — Outpatient Crossover and CT 50 — Inpatient Crossover).

   Do not attach the Medicare RA to this claim.